DIPSOMANIA.

BY PROFESSOR MAGNAN.

(Translated for the MEDICAL ABSTRACT.)

THE dominating influence in dipsomania is heredity. An occasional cause may have a certain action upon particular seizures, but the disturbance is secondary; it has to do only with the manifestation present at the time of attack. Upon the morbid centres of action it has not the importance often attributed to it.

Some writers instead of seeing in the morbid impulse to drink, the manifestation of an interior condition of profound disturbance, regard it as developing only after long periods of alcoholic excess. This opinion, together with that which would make of dipsomania a distinct malady, in an otherwise healthy individual, does not withstand careful investigation. Esquirol saw in dipsomania a distinct malady characterized by an unusual desire to drink, and paid no attention to antecedents. But in order to comprehend dipsomania, this inquiry must certainly be made. Nothing can be more certain than that dipsomaniacs, at various periods of their lives, and many years before the development of their disease, have presented eccentricities of character and serious intellectual difficulties which their after lives have amply accounted for. Other writers have confounded the symptoms of dipsomania with its causes. Dyspepsia, so often regarded as a cause of the drinking impulse, is only a consequence of the malady, though it afterward aids in giving rise to the drinking seizure. The same is true of certain curious conditions to which writers have too readily applied the term hysterical, and which constitute in reality the habitual condition of the physiological life of the dipsomaniac. So also with the periods of melancholy. Far from being the causes, they are the first manifestations of the disease. To menstruation and the menopause have also been attributed a large importance in the causes of dipsomania. Their influence is slight, however, and only at the time of the access, the return of which is sometimes hastened. But even if menstruation has a certain action upon the periodicity of the access, it would be a gross exaggeration to say that it had anything to do with the cause of the trouble.

Marie D—, 45, had been in bad spirits for 4 years—since her husband's death. For 18 months she had been seized at intervals with a violent desire to drink. Then followed a period of deeper sadness and discouragement, which immediately preceded her first seizure. She complains at the time of attack of a constriction of the stomach and the throat. As the impulse increases she reproaches herself and tries desperately to surmount her desire to drink. Incapable, however, of a prolonged resistance, she obtains a supply of liquor and locks herself up for the sole purpose of secret and unrestricted drinking. The melancholy continues to increase and symptoms of alcoholic poisoning appear. Hallucinations take the place of sleep; she sees skulls with flaming eyes and hideous faces grinning at her; objects assume all colors by turns and dance around her bedside. Her skin is troubled with sensations which she ascribes to vermin. The symptoms disappear in a few days and the patient remains sober perhaps for three months, without even a desire to drink. The odor of liquor then becomes so disagreeable as to be almost nauseating. The patient denies that she has a liking for drink. She says that she proceeds wholly against her will. "This is not," she said to us, "a passion with me; it is in spite of myself that I drink." During the attack she becomes irritable and has rushes of blood to the head. In each succeeding seizure the impulse to drink is more imperative and the resistance less powerful. Of this particular case I am unable to speak with certainty concerning hereditary predisposition. Of 8 cases now with us, however, two receive the impulse from both parents and five from either the father or the mother.

The term monomania, introduced into science to explain "a kind of mental alienation characterized by a partial obscuration of the intelligence, of the affections, or of the will," is daily losing its force. In a general way I reject monomanias absolutely, without denying that certain impulses may be the most striking features in certain forms of insanity. But they can have only a symptomatic value. Monomania is but a mental condition in the midst of which a particular tendency manifests itself. It is not the essential disease, though it sometimes so dominates and absorbs the patient's mind as to give his trouble a special appearance. Enough will be shown to prove that if the necessity of drinking is, in the dipsomaniac, the most striking act, it does not constitute the disease. It is an episodical syndrome of a more profound mental state which is governed by heredity. One of my patients had suicidal melancholia, followed in turn by religious mania, nymphomania and homicidal impulses. Observers should be able to understand from such a case that all of these manifestations, far from being monomanias, are different presentments of a single pathological state.

Dipsomania is essentially intermittent in character. The alcoholic delirium which becomes associated with its seizures after they have become very frequent, is a complication, not a symptom. The attacks of dipsomania leave behind them a cerebral restlessness which

lessens by degrees, when the patients, regretting their excess return to a habit of sobriety. The attack is always preceded by similar prodromas. Some of the important symptoms are noted in the following case:

Louise B., 23, daughter of a drunkard whose father was a suicide; mother intelligent; patient's brother died of hydrocephalus. At 20, Louise had periods of melancholy, nervous twitchings of the stomach, and a feeling of weight in the hypogastrium. The phenomena increased at the catamenial period. She had already remarked that a little wine allayed the uneasy feelings in the stomach. She married and became pregnant. She then became more melancholy and lost much of her interest in life. She felt a disgust for solid food and began to have an incessant thirst which would not be allayed, together with extreme heat and dryness of the throat. She began by using peppermint water, but soon commenced to take wine freely and finally decided upon small quantities of spirits. The relief she experienced caused increased drinking, and within a short time she became on one occasion completely intoxicated. Then she remained absolutely sober for 15 days. Melancholy soon seized her again and, after a short struggle, she found that she must soon give way. Fearing the reproaches of her friends she left home with her portable property which she soon disposed of at insignificant prices. Then she bought a bottle of brandy, and taking a room at a hotel drank until she rolled to the floor unconscious. Her husband found her and took her home, but his protestations were useless; she continued her habit at intervals until her child was born, an event which, strangely enough, took place at term and without accident. She now carried her excesses still further, and added absinthe to her list of excitants. Then this woman, so chaste and reserved in her intervals of sobriety, lost her modesty with a very remarkable facility, not only when under the influence of liquor, but when simply dominated by a desire to drink. For a drink she would give herself to the first comer. The saloons of the lowest order served her on these occasions as a place of refuge, and it was in the midst of the most degraded people and in company of the lowest prostitutes that she gave herself up to the most shameful forms of debauchery. Sometimes she was obliged to leave a considerable portion of her garments to pay the cost of her potations. The agents of police had found her more than once, lying in the street in a state of almost comlete nudity. The crisis past, the lady regains her self-possession, becomes profoundly grieved and makes resolutions which beyond question are sincere. She was then docile and ready to assist her friends in any effort they made for her. They placed her in a commercial house hoping that regularity of life and constant surveillance would benefit her. She did well for a time, but a single glass of wine broke through all of her precautions, and in 24 hours she was in the gutter. She was now sent to the house of a relative—a physician—where she improved for a short time. Soon afterward her husband on entering his house found her lying fully intoxicated and almost nude upon the floor of her home. On one occasion she remained 4 days from her friends without food, but almost wholly intoxicated with absinthe. She sometimes went into the streets at night and wandered about while waiting for the opening of a liquor saloon. At another time her husband found her at the Prefecture of police—she had been found drunk and nearly naked, lying in the street. Once, when apparently free from her appetite, she went to walk, taking her little child with her in the belief that she would thus have the firmness to resist any temptation. She thought it no harm to take a glass of wine on the way as she felt some bodily distress. Her distress was in reality a seizure. She confided her child to a drunkard—a stranger whom she encountered—and did not return until the next morning when she was accompanied by a workman whose services she requested. Some days afterward she was sent to friends who agreed to watch her; but she soon escaped and wandered to a distant quarter of the city where she was arrested and fined for drunkenness twice in two days. To-day, the effects of these excesses remain profound and durable. Louise has lately drank habitually until she has fallen, unconscious, into a condition of complete prostration; she often remains in a state of hebetude for 5 or 6 days. Since she has been brought to the Saint Anne Asylum she has been calm and reasonable. She fully understands her terrible situation and has often, she says, made up her mind to destroy herself. But she drinks alcohol to give her the necessary courage and takes so much of it that she soon loses recollection of her intended suicide and gives herself up to debauchery.

Although in dipsomaniacs the impulse to drink is preceded by the same prodromas, persons of education soon perceive their malady and, for a long while, show much ability in concealing their habit. The struggle these people often make against their impulses indicate in the clearest manner how widely they differ from ordinary drunkards. The latter seek occasions to drink. The dipsomaniac avoids them, reproaches himself deeply for his impulses, and often seeks by a thousand means to destroy his desire for liquor. He even soils

his drinks in the most disgusting ways in the effort to sicken himself with his destroyer. The ordinary drinker does not do this.

Madame N. was a woman of a serious character, regular and of irreproachable habits. She became suddenly seized with a drinking impulse which became irresistible. She put in her wine substances calculated to inspire disgust—even excrement—yet she still craved for more liquor, and finding such to be the case would curse herself horribly. "Drink, then, drink, miserable drunkard!" she would exclaim, "go forth, dishonor yourself and your family." And she would do so though often sober at the time.

When the dipsomaniac ends by succumbing, he does not behave like the ordinary drunkard. In the early stages of the disease he drinks furtively and generally conceals himself. The professional drinker is noisy, seeks companionship and in most cases disputes, or relates his own exploits. The one is insane before he drinks, the other becomes so because he drinks.

Marie T., 51, maternal grandfather a suicide; mother, at 40, was affected with melancholia. Patient was a Child of the Regiment [*cantiniere*], and sometimes drank a little *eau-de-vie*, not because she cared for it, but, as she said, "it belonged to the business." The curious point in this case is that though she was in reality a latent dipsomaniac, the disease did not then seize her, and when she left the business the habit of drinking ceased. At 34, however, she complained of cramps in her right hand so severe as to compel her to learn to work with her left. Then the sensibility of the member slowly left it. Two years later, without apparent cause, she had an attack of melancholy. She tried to dissipate it by using a moderate quantity of brandy, but only succeeded in losing her sleep. This attack was not yet, properly speaking, a well characterized seizure of dipsomania. But some time afterward the woman fell into another condition of melancholy and suffered acutely for two days. Then followed stomachal spasms and at the same time a desire to drink strong liquor which soon became irresistible. She left her locality to escape observation and began the "run of the cabarets." These attacks continued and were brought about, she thought, by horrible burning sensations in the stomach, and a feeling of obstruction of the throat. Alcoholic accidents brought her at last to the Pitié hospital, where, however, despite her abstinence the mental disease which brought about the dipsomania steadily continued its course. Ideas of suicide pursued her steadily. She succeeded on one occasion in precipitating herself from a staircase. Finding that she was not seriously injured she crawled higher up and was about to jump when she was restrained. "A voice," she said, had commanded her to do this. On the following night she attempted to strangle herself with her clothing. Her hallucinations became terrifying. For 18 months this condition has not been modified.

As showing how dipsomania may exist without any alcoholic excess for months previous, the fact may be cited that she was once seized in the middle of the night with an attack of the disease, accompanied by frightful hallucinations. When the attack was over there was left but one hallucination; a voice was continually saying to her, "It is vain to resist, you will end by killing yourself." This patient has developed a remarkable peculiarity. When she walks with another patient, she is always careful to place her at her right side, for it is impossible for her to feel the presence of anyone at the left. All objects that she looks at with the left eye seem to her to oscillate. Her arteries are atheromatous; all of her organs of sensibility on the left side are weakened.

As to the liquors chosen by dipsomaniacs, all are good enough if they contain alcohol. One patient, however, the Count de R., who is well known in the medical world, has a preference for ether and sugar. His mother—also a dipsomaniac—has the same habit, and sometimes bathes herself in ether. Both of them, however, will seize any intoxicating liquor which comes to hand when the fit is on. A marked difference between the dipsomaniac and the drunkard is, that between their potations the latter has no special dislike to his favorite drink, while the dipsomaniac feels for it an almost insurmountable repugnance. Our first-mentioned case cannot, when sober, support the odor of her customary drink; of the two other patients, one drinks water habitually and the other will go for days without taking any liquid whatever.

The state of exhaustion and self-humiliation in which the dipsomaniac finds himself after he has recovered from his seizure, should not be confounded with the phase of melancholy which precedes the attack. The prostration is a consequence of mental and physical fatigue, and especially of the repentance and despair which follow his act. His discouragement often leads to suicide, and his contemplation of such an end is almost always persistent. Sometimes he becomes very dangerous from the fact that the suicidal impulse is often complicated with the homicidal mania.

Louis H., 35, father drunkard, attempted suicide, mother hysterical. Patient has always had a predisposition to melancholy and his sadness is increased by the belief that he is a natural child. He knows "how it will all

end," for his mind has for several years been haunted with ideas of suicide. In Lyons he threw himself into the river through fear of entering barracks after one of his attacks. Later, after the rupture of a long contemplated marriage, he had a period of melancholy, during which he drank for 4 or 5 consecutive days. He then hung himself above the door of the lady to whom he had been engaged, but was rescued. Four years later, from a motive *which he does not even remember*, he attempted suicide, after one of his seizures. Later he was stopped as he was about to leap from the Austerlitz bridge. The following year, during another seizure, he attempted to open his veins in a bath-tub, but was surprised in the act by the attendant who had been struck with his wild appearance. He tried to poison himself, but his stomach rejected his mixtures; he afterward made a further attempt at suicide which was equally abortive. Every 3 or 4 months he appears progressively melancholy and the seizures are much more marked. He loses appetite, complains of pain and constriction in the stomach; his head feels as though bursting; his sight is troubled—he feels as though trying to see clearly in a fog—and then comes the irresistible thirst for liquor. After drinking for 3 days he resumes work and his ordinary appetite returns. Apart from his attacks of alcoholic delirium this patient has some of the ideas of persecution. He often believes himself followed by men in the street who menace him with knives. Sometimes he hears at his left ear threats and insults of all sorts. Simultaneously at the right ear he hears agreeable things. For three years he has been troubled with an interior voice which urges him to strike at the life of some one. He fears greatly that he may one day give way to this impulse as he has to the others. The sight of a knife causes in him a painful impression; he never touches one when he can avoid it.

The attacks of dipsomania last from 2 to 15 days. At the commencement of the disease, they occur generally but once or twice in a year and grow in frequency until they become separated by an interval of a few days only. Writers have altogether too strongly insisted upon the resistance of the constitution of dipsomaniacs to the effects of alcohol. When the quantity taken is sufficient these unfortunates will, sooner or later, be subject to the toxic delirium of the ordinary drinker in addition to their own special symptoms. At first, drunkenness, which alone accompanies the seizures, leaves no trace, but as these crises come so nearly together as to act continuously, toxic symptoms will develope. Sometimes a true dipsomaniac comes to the asylum suffering from common alcoholic delirium, and it is only after the acute symptoms have disappeared that we find the profound indications of the principal malady. The coexistence in the same patient of several different species of delirium is a demonstrated fact.

Hortense B., 53, whose father was a suicide, remained temperate until 40. She married at 20, and was a widow 8 months afterward. From 21 to 27 she suffered from irregular attacks of gastralgia followed by vomiting. At 31 remarried; became greatly troubled through business losses. Drank occasionally, but was rarely intoxicated. It was much later when the gradual developement of dipsomania attracted her attention. The symptoms were pains in the head and stomach, pressure upon the back and the epigastrium, repugnance to food and insomnia. She was restless, sad and discouraged. Was filled with strange fancies. Everything wearied her; trifles exasperated her; a hallucination which seemed to her as "an image of death," pursued her without ceasing. So great were her other troubles that she hailed this last appearance as an object which would soon bring deliverance. It was in this condition that she felt her first irresistible impulse to drink. She soon went from wine to brandy without being able to quench her thirst and in a few days had an attack of alcoholic delirium—apart from the dipsomania affection—and while suffering from hallucinations of sight and hearing. She believed she saw the dread shadows of the Commune and heard the musketry. She thought that all who met her in the street reviled her. Life became insupportable and she had been taken to the asylum in toxic delirium after a determined attempt upon it. Discharged in 3 months, she quietly and soberly resumed her work and remained in good health for 15 months. Then an attack like the first one led her to drink for several successive days and sent her again to the asylum. After her discharge came a further period of perfect sobriety for 8 months, followed by a further attack which ended in deeper mania and more terrible hallucinations. She believed herself about to be cut into pieces, thought she was to be arraigned for assassination, and even falsely complained to the police that a person in her house had killed a child. She was again taken to the asylum and again discharged and continued in this way for 4 years, with perfectly sober intervals lasting 6, 8 and 15 months, when she was troubled with neither melancholy nor unnatural thirst. The fourth time she was admitted, she had attempted suicide and on the fifth was suffering horrible anguish from hallucinations in which she believed that dead persons whom she had known when living were talking to her. She

thought her mother was not only reproaching her but beckoning her to follow her shade to the regions beyond.

There are some dipsomaniacs who, outside of their periods of impulse, behave at times like common drunkards, and live under the worst possible hygienic conditions. These patients frequently end their lives in chronic alcoholism. But it is always possible to determine whether the person drinks from unhealthy impulse or because he has adopted drunken habits. Impulsive drinking is always preceded by a phase of melancholy, and is characterized by a thirst which causes the victim to drink glass after glass in quick succession; he is filled with shame and constantly makes desperate efforts at reform hoping, on each occasion, never to fall again. His resolves are pathetic in their perfect sincerity. Our last patient has sent us a note in which his promise never to drink again is written in his own blood.

The mental state of some dipsomaniacs is such, in the intervals of the attacks, that on a superficial examination one would believe them wholly cured; their frequent lucidity of mind gives a misleading impression as to the real condition of their faculties. These appearances have caused them to be considered, even by some of the most eminent alienists, as subject to a sort of partial delirium. But a careful nvestigation of the patients' lives shows that there is no need of creating for them a special malady whose chief characteristic is an irresistible passion for fermented liquors. It is always possible, thanks to an attentive observation of pathological facts, to reduce these depraved tendencies to their true generative causes. These are simply hereditary predisposition. The acts of the dipsomaniac always demonstrate that he is unbalanced. "But they are only insane," say some of the writers, "when their attack comes on." This is an error. Dipsomaniacs present a host of other weaknesses which make them beings having a tendency to act from perverted instincts [*êtres instinctifs*] and are possessed with all sorts of evil tendencies whose objective point varies according to education and surroundings. The essentially unhealthy nature of these beings should be too clearly understood to need demonstration. Among their most salient impulses are those which lead to robbery, suicide, homicide and the erotic predisposition. It appears as though chance may decide the particular direction of their morbid disposition, but none escape their logical ending. All are subject to similar impulses though, it may be, under different forms. All, or almost all, have insane antecedents; many present peculiarities of mind from infancy. A man, now an ether drinker, states that in childhood he had already made two attempts at suicide, the first at 9 years because he had been punished unjustly, the second at 16 because he had been separated from a friend. When his family vexed him he used to push pins into his body knowing that they feared he might open a vein. The physical development of the dipsomaniac also presents certain peculiarities in infancy. They develope too early or too late in the matter of intelligence, and show phenomena of a nervous, convulsive nature; they often develope chorea. It is not rare also to find certain hysteric manifestations, which explains to a certain extent why dipsomania is more frequent in women than in men.

If dipsomaniacs are not always in delirium they constantly keep one foot in the domain of insanity. Without doubt the patient is wholly different in his paroxysmal state from what he appears when in his remittent period; but many, even in their lucid intervals, conduct themselves like the veritably insane. Most all of them are not only unbalanced but fantastic, with the ever present tendency to sadness; they exaggerate in all things; with few exceptions they are reasoning fools. To interrogate them is sufficient to demonstrate this fact. It is hardly possible to imagine a more dramatic and tempestuous life than it is the destiny of one of these unfortunates to lead. I will give a case in point.

Eugénie M. is a school-teacher of 48, father was a drunkard, and her grandmother (maternal) drowned herself. Has two brothers in good health. Her early youth was passed without notable illness. At 20 she felt drawn to a religious life, entered a convent and gave herself with fervor to a monastic life. Was nourished poorly, practiced fasting and abstinence, and slept little, giving up a portion of her nights to self-discipline. The Superior pointed her out as a model. Eugénie's first hallucination soon appeared, she thought herself surrounded with the heads of angels. This soon gave place to the shadowy appearance of one of her religious companions, the extreme tenderness of whose expression affected her so profoundly that she fell into a condition of ecstacy which lasted for some hours. The circumstance naturally created a strong affection between the two, and, at times of religious ceremony, when they were unable to speak together, they spent hours in looking into each others eyes. But their affection did not remain confined to those straight paths of mysticism in which it took its rise. I will not speak at length of the details in this matter. They secretly held continual conversation, and that after a time Eugénie and the other carmelite abandoned themselves to mutual caresses, and gave themselves to masturbation.

Thirty years have passed, yet Eugénie in relating the circumstances to us stated that the thought of them even now made her almost beside herself. "I have a remorse mingled with shame," she said to us, "which after all gives me a certain kind of pleasure." At another time she said, "You would hardly believe how painful it is to be obliged to reproach myself for the most agreeable souvenir of my life." Following these practices she fled from the convent one day and looked for a husband. But the man of whom she dreamed was in no great hurry to marry. Then she was sorry she had broken her vows, and this fact followed by the threatened rupture of her negotiation of marriage led her to despair and she attempted suicide. Saved from this, she was the victim of further troubles, and then she commenced to drink, though in very small quantity. Married at last, her husband excited her by taking a mistress, and she drank more freely. This condition increased and she commenced to talk injuriously of her neighbors and to create scandal. One day she struck her husband, and on another occasion she struck him brutally in the midst of a large company at a dinner party.

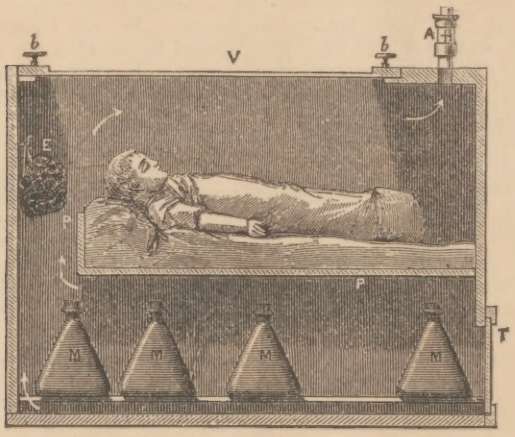
Eugénie gives an excellent account of her condition at that time. At present we observe the continued growth of dipsomania, she feels the irresistable longing, yet once it is satisfied may go for many days without the least desire to drink. The symptoms of attack in her are not unlike those of the others. She becomes sad and irritable, has headache, contraction of the stomach and a choking sensation in the œsophagus. She is one of those who mixes fecal matter and petroleum with her liquor without bringing about the disgust she hopes for. After the suicidal impulses become pronounced, homicidal ideas appear. Sometimes she wishes to strangle her husband. Sometimes even, as she states, the idea occurs to her to kill persons for whom she has no enmity. Her husband finally became discouraged. Fearing that his wife might not always resist her desire to kill him, he left suddenly for Australia and has not since been heard of. Eugénie, although assisted by her brothers, could not resist the force of her predispositions. One night her brothers became entangled in a crowd who were watching a drunken woman lying in the gutter—it was their sister. Hastily writing on a piece of paper the words, "If you have any heart left you will for the honor of the family disappear to-morrow," one of them put the billet in her pocket. The consequence was that Eugénie forthwith jumped into the Seine. She was rescued and made many other attempts at suicide which also miscarried. She was arrested many times and often wandered for days without eating, but drinking all she could obtain. She was now subject to terrible hallucinations and impulses. The latter took physical form; one day she armed herself with a knife and attacked the brother who had written her the note. This brought her again to the asylum. "I reason well enough," she remarked, "yet no one is more crazy than I am." She easily returned to a lucid interval, became reasonable and resumed her habits of work. But the inevitable attack recurred. This time she made a desperate resistance, prayed with fervor and passed days in the churches. But the hallucinations redoubled and one morning she was picked up completely drunk and lying upon the steps of a church. Since the departure of her husband, Eugénie had been living with another man. This individual always tried to restrain her by force from drinking. At such times the woman would not hesitate to implore the assistance of her brothers to shake off the man, declaring in such moments that he was a perfect stranger to her. Once her attack was over, she would write him the most affectionate letters imploring his pardon and promising not to recommence her habit. On one occasion, after a stay of 3 months in the hospital, she had a very marked attack. She felt it coming and purged herself, though with no preventive effect. She was extremely restless and went to bed, but rest was not to be had; nightmares awakened her almost as soon as she commenced to sleep. A cold sweat covered her and her body grew icy. This condition, counting from the first day of uneasiness, lasted for nearly a week before she felt the need of drinking. Her thirst was very great, and her throat so parched as to leave her hardly enough saliva to enable her to speak. She ran at last to a rum-shop where she hastened to intoxicate herself and then took refuge in a partly demolished house where she passed the night. At dawn she returned home and went to bed for 3 hours without taking anything but some milk and a little broth. Both wine and beer disgusted her and it looked as though the attack would prove abortive. Three days afterward, however, the seizure returned in full force; she drank all day, slept in a cellar away from home at night, and on the following day locked herself in her chamber for 10 days without drinking a drop of liquor. In one of her attacks she determined not to give way, and accordingly soiled her quart of mixed wine and brandy with fecal matter. She slept awhile, but when she awoke she swallowed the frightful mixture with avidity. In the short time between the good resolution and the full onset of the disease her sufferings had become insupportable tortures. Taste, hearing and

smell were involved, her body burned in agony and her mind was filled with fears and hallucinations. Her curious experiences have been almost numberless and they continue to grow worse. At this time she has an incomplete hemianesthesia, with a general weakness of all the functions of sensation. The pricking of a pin is almost unnoticed and the sensation of cold produced by ice water cannot be felt. The right ear appears to be reserved for the constant hearing of all sorts of supposed revilings from those she meets, while the pardons of an offended Deity and the encouragements of friends seem to be heard only on the left side. "It has always been so," she said, "even when I was at the convent 20 years ago;" *that is, before she had tasted liquor at all.*

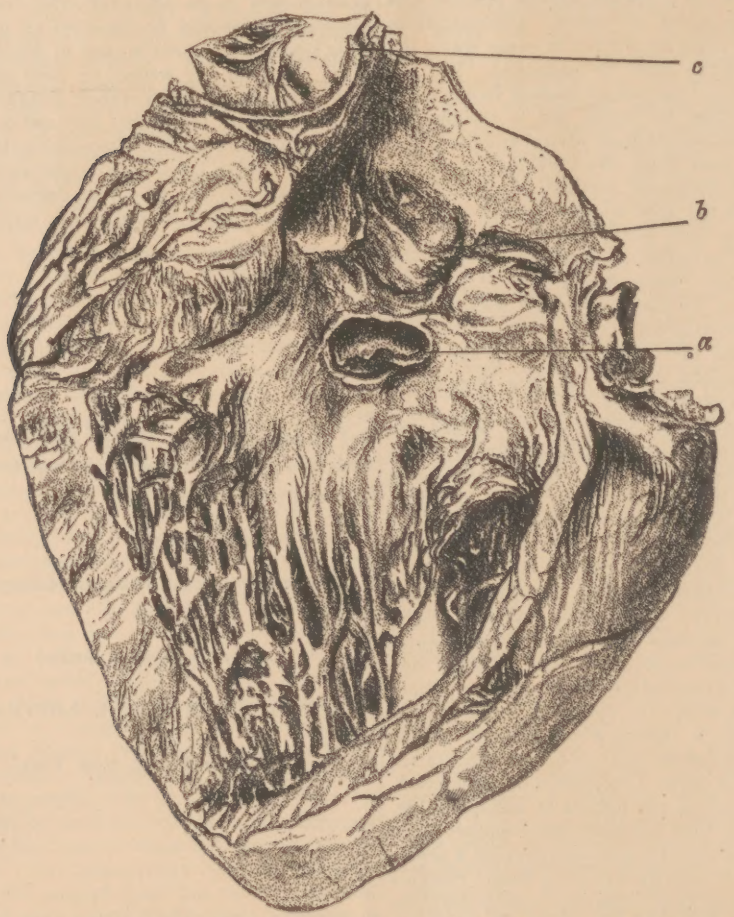
There are two indications for the treatment of dipsomania: first to combat toxic accidents and afterward to attempt to modify the course of the disease itself. As to the first, the patient must be protected against himself and from doing injury to others. Elimination of the poison must be favored in every way; the physical forces must be sustained. For the modification of the deeper malady moral treatment is useful, no doubt, but is insufficient. Distractions, affectionate advice, and the ablest reasoning have little effect during the active period. Hydropathy methodically used, and particularly the cold douche applied upon all parts of the body except the head, give good results. The action of arsenic upon the general nutrition commends it greatly in these cases, and if its use is continued there will be more or less long intercalary periods of repose. My formula is: ℞. Aq. dest. gram. 200; Sodii Arseniatis. centgr. 10; Aq. dest. prun. laurocerasi gram. 4. M.

When excitation and insomnia persist, recourse must be had to warm mucilaginous baths—those of elm wood for instance—and doses of 4 to 6 grammes brom. pot. at night. Preference should be given to the polybromides if the treatment is to be long continued. Sometimes the patient is deeply depressed and sulphur baths are indicated. Great benefit will also be derived from vapor baths of warm turpentine followed by immersion in cold water or an application of the douche. This is one of the most powerful alteratives and the patient rarely fails to be very favorably influenced by so energetic a therapeutical method. Good hygienic treatment and a tonic medication are necessary in using this system of alleviation. The isolation of the patient is indispensable. This will in time attenuate the impulsive predispositions and if it does not prevent a reproduction of the attacks, will delay them. Patients have had attacks of dipsomania with delirium despite the total discontinuance of spirituous liquors. Do not forget that patients must always be watched for suicidal or homicidal indications. The daily use of bitter drinks is recommended; it calms the desire of the patient for "something strong."

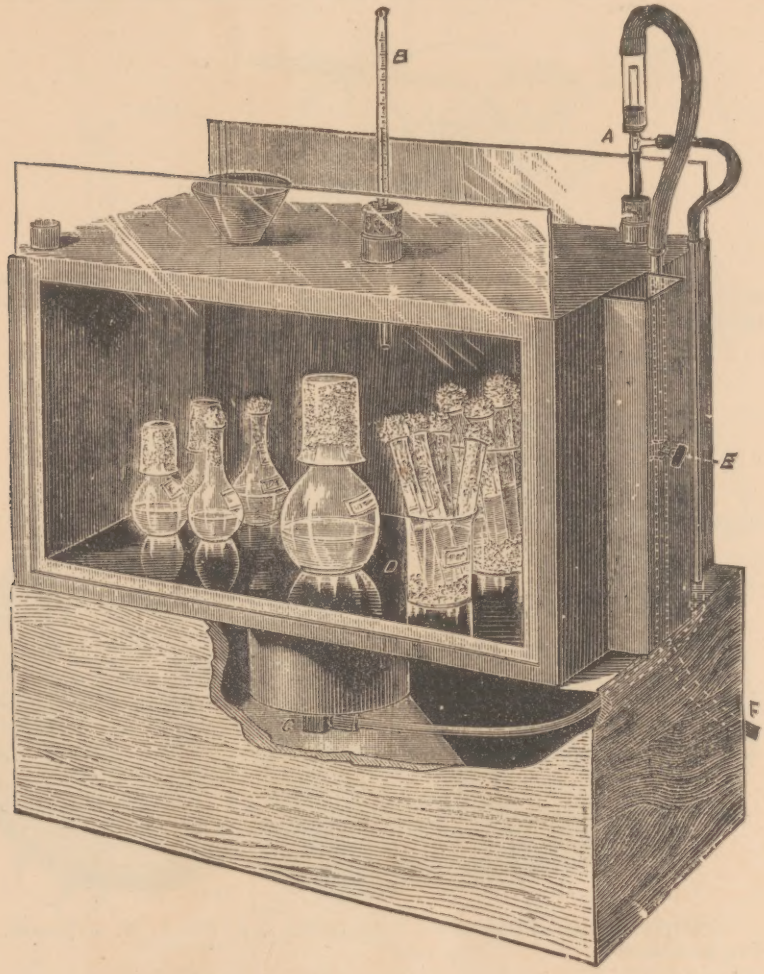
A large number of medico-legal questions arise in connection with dipsomania. We have seen that these patients have tendencies which are susceptible of interpretation through impulses of a diverse character. Hence, to become completely certain upon this subject it would be necessary to make a complete medico-legal history of hereditary insanity. But it may be said that all true dipsomaniacs are irresponsible for acts committed immediately before, during, and after their attacks. This is on account of their intellectual condition before the crisis, on account of the impulsive character of their actions, and on account of the toxic delirium with which it is often followed. In the eyes even of those who regard drunkenness as an aggravation of crime, the dipsomaniac should be regarded as irresponsible because he is not master of his desire to drink. As for the wrong, or even criminal, acts which they commit in their lucid intervals, we should never forget that they are possessed of a undeniably morbid disposition, that they have a defective intellectual organization, and are in reality beings who have degenerated.—*Le Progrès Médical*, Nos. 4, 5, 6, 8, 10, 12; 1884.

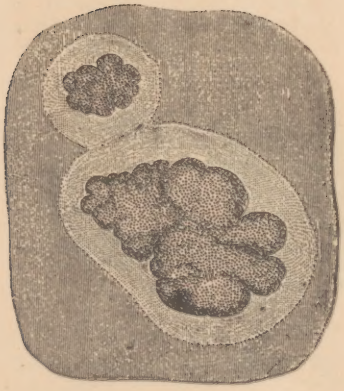


THE COUVEUSE FOR CHILDREN, M A. Auvard, translated from the French for the MEDICAL ABSTRACT. This is from the original article on the subject, and gives all the illustrations which appear in the original—six.



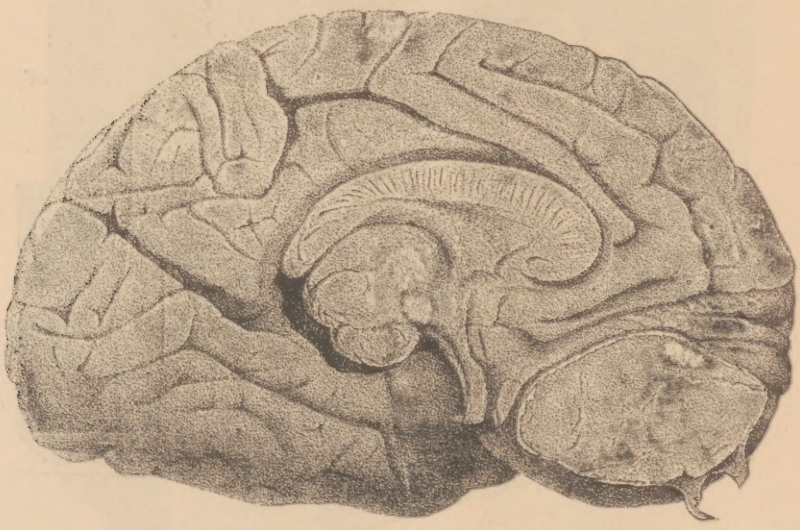
MALFORMATIONS OF THE HEART IN THEIR RELATIONS TO THE PATHOLOGY OF CYANOSIS, David Newman, M.D. Six illustrations.





MICRO ORGANISMS AND DISEASE, E. Klein, M.D. This is the most complete article extant on the subject upon which it treats. It is illustrated by about one hundred cuts, showing microscopic views of the various micrococci and bacilli existing in disease. The article is very complete, giving cuts of the incubator etc., and describing methods and other matter down to the minutest detail.

LABOR IN CENTRAL AFRICA, Robert W. Felkin, M.D: A valuable article, illustrating the various modes of delivery in vogue in Africa. Twenty-two illustrations.



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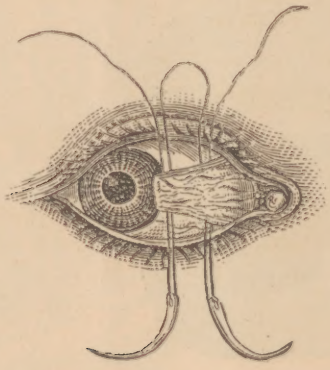
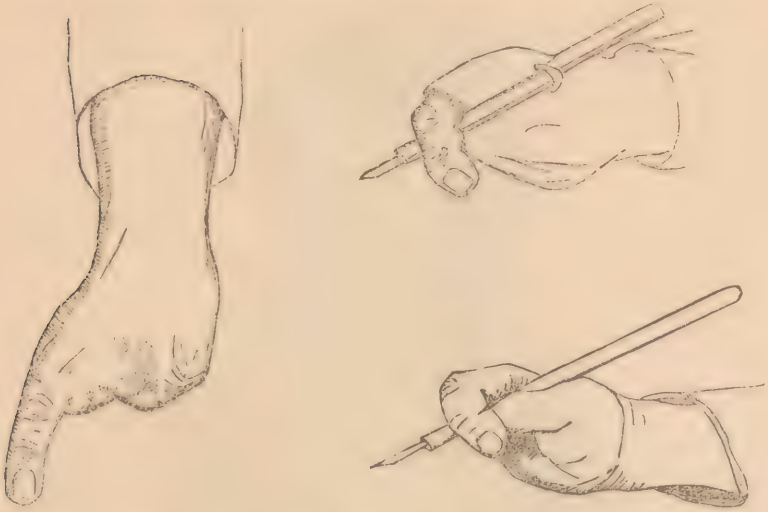


DISEASES OF THE EYE AND THEIR REMEDIES, Archibald H. Jacob, M.D., Dublin. Over thirty illustrations showing the eye as it appears in its various diseases. Not yet completed.

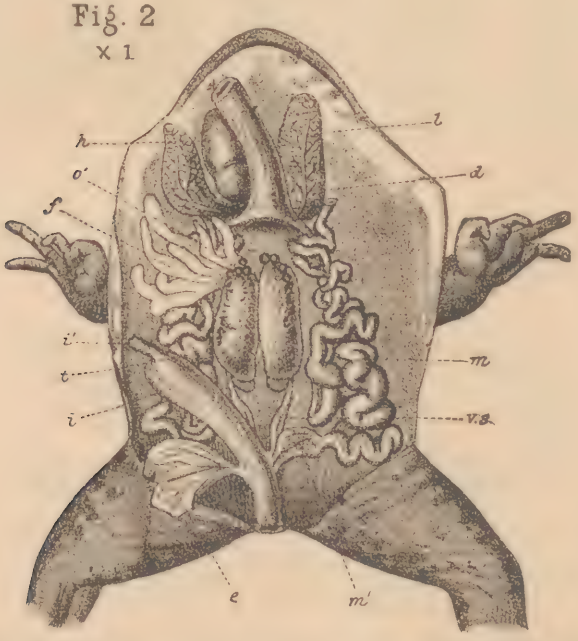


PROGNOSIS AND TREATMENT OF MUTILATIONS OF THE HAND, Dr. Fr. Guermonprez. From the French, twenty-eight illustrations. This is a humane article and well worthy of study.

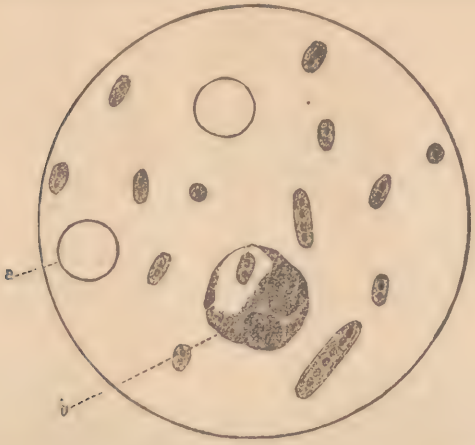
THE SENSORIAL LOCALISATIONS IN THE CORTEX CEREBRI, Luigi Luciani, Florence. An interesting and valuable paper to those interested in brain diseases, four illustrations.

ABDOMINAL SECTION AS PART OF THE SURGICAL TREATMENT OF SOME DISEASES OF THE ABDOMEN, J. Stuart Nairne, M.D. A very practical article on the subject, with many illustrations of instruments, etc.

MODIFICATIONS OF THE OPERATION FOR INTERNAL AND EXTERNAL SQUINT, Charles Bell Taylor, M.D., six illustrations, showing the eyes before and after operations.



CERTAIN ABNORMAL CONDITIONS OF THE REPRODUCTIVE ORGANS IN THE FROG, A. Milnes Marshall, M.D. Thirteen illustrations on plate paper.

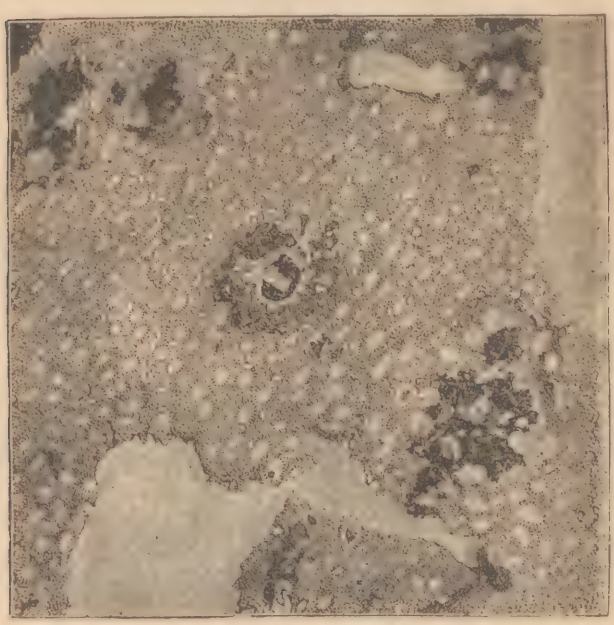


THE MICROCOCCUS OF PNEUMONIA, Dr. P. Bricon, from the French. Eight illustrations.

STUDIES OF POSTURES INDICATIVE OF THE CONDITION OF THE MIND, AS ILLUSTRATED IN WORKS OF ART, Francis Warner, M.D. Six illustrations.

Closely related to this subject, and by the same author the ABSTRACT has published *Study of the Face as an Index of the Condition of the Brain*, and *Spontaneous Positions of the Hand Considered as Indications of the Condition of the Brain*. All the articles are interesting, and we hope soon to publish more from this writer's gifted pen.

CHOLERA AND ITS BACILLUS, Robert Koch, M.D. This is a very interesting article on the subject of cholera and is well worth the attention of every physician. It is practical as well as scientific, eleven illustrations.



MICROCOCCI IN RELATION TO WOUNDS, ABSCESSES AND SEPTIC PROCESSES, W. Watson Cheyne, M.B.; 13 illustrations. A very interesting article.

The illustrations given here show but a small part of matter appearing in the ABSTRACT during the year, but they will serve to indicate its scope and value.

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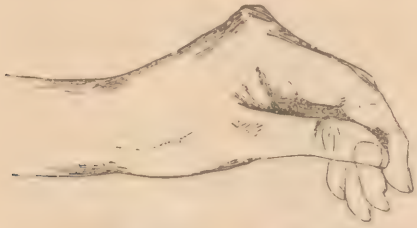
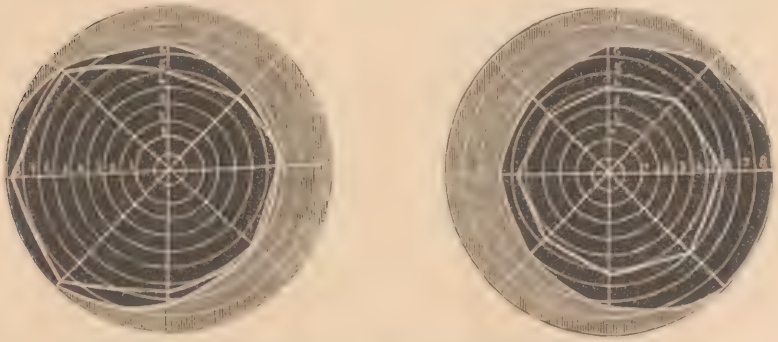


HYSTERICAL CONTRACTION OF TRAUMATIC ORIGIN, M. Charcot. Translated from the French.



VARIETIES OF APHASIA: VERBAL-BLINDNESS AND WORD-BLINDNESS, by the same author. Ten illustrations.

THE HOTTENTOT VENUS, M. L. Capitan. Six illustrations. From the French.

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